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WINNING MEDICINE: PROFESSIONAL SPORTS TEAM DOCTORS' CONFLICTS OF INTEREST

If a doctor becomes too conservative with the players, he won't be around long. No team wants its players coddled. They pay big money and expect players to swallow their fair share of pain. If this in course leads to permanent injury, again the thinking goes, that's what players get paid for.¹

I. INTRODUCTION

Our society expects physicians always to act according to what is best for their patients.² When the patients are professional athletes, however, doctors often will encounter severe pressures from their employers, the patients, and from their own self-interests to compromise their medical ethics.³ First and foremost, team doctors are pressured by their employers. Professional sports is big business in the United States.⁴ Winning

1. TIM GREEN, *THE DARK SIDE OF THE GAME* 215 (1996).

2. See, MARC C. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 268 (1993) (citing Hippocrates). The Hippocratic oath by which all American doctors swear says:

I will use treatment to help the sick according to my ability and judgment but never with a view to wrong-doing. . . . Into whatever house I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doings and harm, especially from abusing the bodies of man or woman. . . .

Id.

More applicable to the team physician example is the ethical principle that a "physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of medical judgment and skill or tend to cause a deterioration of the quality of medical care." AMERICAN MEDICAL ASSOCIATION, *PRINCIPLES OF MEDICAL ETHICS* § 6 (1957).

3. See *infra* notes 71-141 and accompanying text.

4. For example, the 107 franchises in professional football, baseball, basketball, and hockey approximately are worth a combined \$11.4 billion. *The Business of Sports*, 5 CQ RESEARCHER, 121, 121 (1995); Franchise values have exceeded \$300 million per team. Sam Ward, *Ballyard Sale*, USA TODAY, March 20, 1998, at 17C. The National Football League ("NFL") collected \$17.6 billion in its most recent three year television agreement. Leonard Shapiro & Paul Farhi, *ABC Keeps Mondays in Record NFL Deals; Networks Pay \$17.6 Billion; NBC Out*, WASH. POST, Jan. 14, 1998, at A1; Some National Basketball Association ("NBA") players have signed contracts in excess of \$100 million. *E.g.*, *Garnett: Six Years, \$120 Million*, WASH. POST, Oct. 2, 1997, at E6.

games triggers increased ticket sales, television viewership, and merchandise sales.⁵ Team physicians, often considered part of the team, indirectly can cause a team to lose by properly asserting that a star player physically is unable to perform. Management may work years if not decades for a chance to go to the playoffs or win a title, consequently, owners will not tolerate a team doctor who is so cautious that it causes the team to lose.⁶

Second, athletes also pressure team physicians to compromise medical ethics. Athletes themselves feel pressure to perform on the field for economic reasons as well as for reasons of pride, peer pressure, and the love of the game.⁷

Third, the team physician faces self-imposed pressures to compromise his medical ethics. The association with a professional sports team can result in a substantial amount of business and prestige for the team doctor.⁸ He benefits from the publicity of his position with the team, but does not want the notoriety that would accompany his being fired. Consequently, because all doctors owe their primary duty to their patients,⁹ the team doctor is burdened by constantly having to ignore these pressures in order to make ethical medical decisions.

Management urges or coerces athletes to take long-term risks to make short-term gains for teams.¹⁰ The physician's ethics may place him in conflict with the team's values when he believes that an athlete's health is in danger. The doctor must not allow outside pressure to influence his deci-

5. See, e.g., Chris Haft, *Team's New Look Sells but Winning Means even More Buying*, CINCINNATI ENQUIRER, Mar. 10, 1997, at B5. The 1997 Super Bowl champion Green Bay Packers enjoyed a dramatic rise in merchandise sales despite changing nothing about the team apparel that is sold. Ranking 20th in the NFL in sales in 1992, the year coach Mike Holmgren and Brett Favre, their quarterback, arrived, the Packers rose to 13th in 1993, which coincided with All-Pro defensive end Reggie White's joining the team. They also reached the playoffs that year for the first time since 1982. As the team improved, so did sales to 8th in the league in 1994, 5th in 1995, and 2nd in 1996, a season when the Packers won the Super Bowl. *Id.* Note that NFL teams, unlike some other leagues, share merchandising revenue, *Id.*, but that is unrelated to the correlation between sales and winning.

6. See e.g., Ron Pollack, *Are Injured Players on Their Own?*, PRO FOOTBALL WKLY, Nov. 10, 1996, at 12. When a head coach "turns up the heat", one former player who still is closely connected to the NFL stated that "A lot of times [the team physician] folds. The ones that don't fold end up being fired." *Id.*

7. See *infra* notes 75-97 and accompanying text.

8. See *infra* notes 119-141 and accompanying text.

9. See RODWIN *supra* note 2.

10. Thomas H. Murry, *Divided Loyalties in Sports Medicine*, THE PHYSICIAN AND SPORTS MEDICINE, Aug. 1984, at 136 (explaining that it is management's inherent interest in winning that tempts management to coerce athletes to take risks which may have long term health consequences).

sions. It is not easy to make clear judgments, however, when an employer is telling the doctor, an employee, to get the players ready to play as quickly as possible, the player is telling the doctor to get him back into play as quickly as possible, and the media and the fans want the player to play as quickly as possible. These outside pressures gain even more strength when combined with the fact that the team physician personally may feel as much pressure to win as anyone associated with the team.¹¹

Unfortunately for the team doctors, few guidelines exist concerning how to deal with the conflict between the pressures to win and the standards of medical ethics. Certainly, the American Medical Association ("AMA") has stated that the interests of the patient, here the athlete, should be paramount in the practice of medicine.¹² Similarly, the World Medical Association ("WMA") has established rules which state that the health of patients must be the first consideration¹³ and that a "doctor owes to his patient complete loyalty."¹⁴ Legal standards for all specialties recognized by the AMA have been established, but the AMA has not recognized sports medicine or the team physician role as a specialty or subspecialty.¹⁵ However, the American College of Sports Medicine has established some guidelines.¹⁶ Those guidelines only say that when confronted by pressures from coaches and athletes, the team physician has the obligation to put those pressures aside when providing treatment.¹⁷ The guidelines do not address how to do so or where to draw the line.¹⁸ For example, what does a team doctor do when he thinks that a player should not play, but that player is adamant that he is capable of playing? That player could be lying or concealing information, perhaps because the owner has threatened or might threaten his job. It even might be unclear whether or not that athlete is lucid enough to make a decision

11. See *infra* notes 119-141 and accompanying text.

12. RODWIN, *supra* note 2, at 41-42 (citing AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AFFAIRS. CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS 56 (1989)).

13. RODWIN, *supra* note 2, at 268 (citing 1 WORLD MED. A'SSN J. 109-11 (1949)).

14. *Id.* at 269.

15. ELIZABETH M. GALLUP, LAW AND THE TEAM PHYSICIAN 9 (1995) (citing to the AMERICAN BOARD OF MEDICAL SPECIALTIES ANNUAL REPORT 6-7).

16. AMERICAN COLLEGE OF SPORT MEDICINE'S GUIDELINES FOR THE TEAM PHYSICIAN, (Robert C. Cantu & Lyle J. Mitcheli eds. 1991) [hereinafter "ACSM"]. This source provides general guidelines for team physicians at all levels. Different team physicians have varied duties depending upon the team and the sport. Therefore, the ACSM guideline will be only one source in a mix of sources that may be used to determine the standard of care for a particular team doctor. GALLUP, *supra* note 15, at 10.

17. ACSM, *supra* note 16, at 123-24.

18. *Id.*

concerning his present and future health. What if that athlete is essential for the team to make the playoffs, and the doctor is a lifelong fan or could really use playoff bonus money to help support his family?

The purpose of this Comment is to demonstrate to both physicians and attorneys that legal conflicts of interest exist for team physicians. First, this Comment explains the legal standard of care as it now exists for team doctors. Second, the pressures that team doctors face, which create conflicts of interest for them, are fully examined. These overwhelming pressures demonstrate how difficult it can be for a team physician to maintain clear, unbiased judgment when having to treat professional athletes. Third, this Comment presents the case law background which will demonstrate both how these pressures have resulted in team doctor liability and what has been found to be liable conduct in the past. Finally, this Comment reveals and analyzes solutions to the possible conflicts of interest facing team physicians both by demonstrating some ways that team doctors can protect themselves and ways that negative pressures that these doctors face can be decreased.

II. LEGAL BACKGROUND

A physician has a conflict of interest when competing interests or commitments compromise his independent judgment.¹⁹ These conflicts can motivate doctors to act in ways that may not favor patients.²⁰ Conflicts of interest may increase the risk that physicians will abuse their patients' trust.²¹ Yet, conflicts of interest are not "acts" and they do not ensure disloyalty to the patient.²² In order to recover for medical malpractice a plaintiff must establish the following elements: 1) a duty owed to the plaintiff based upon the doctor-patient relationship;²³ 2) a breach of the standard of care;²⁴ 3) an injury;²⁵ and 4) a causal connection between the breach and the injury.²⁶

Due to the variety of arrangements reached with physicians to provide

19. RODWIN, *supra* note 2, at 9.

20. *Id.* at 8-9.

21. *Id.* at 9.

22. *Id.*

23. Charles V. Russell, *Legal and Ethical Conflicts Arising from the Team Physician's Dual Obligation to the Athlete and Management*, 10 SETON HALL LEGIS J. 299, 301 (1987) (citing *e.g.* Pohl v. Witcher, 477 So. 2d 1015 (Fla. Dist. Ct. App. 1985)).

24. *Id.*

25. *Id.*

26. *Id.*

medical care to athletes, a team physician is not precisely defined.²⁷ One attempt defines such a doctor as "a physician who undertakes to render medical services to athletic participants and whose services are either arranged for or paid for at least in part by the institution or entity other than the patient, the patient's family, or some surrogate."²⁸ Since these physicians have no duty to enter into this contractual relationship,²⁹ the doctor-patient relationship is deemed consensual.³⁰ Regardless of the original purpose of the examination, the goals and expectations of the patient, or the party paying the physician, a team physician always owes his patients a duty not to inflict injury by some misfeasance.³¹ There is also a general duty to take the necessary action and exercise reasonable care to prevent harm, or further harm, to the patient.³² This duty is created either contractually through the third-party beneficiary theory³³ or through tort theory which imposes a duty of due care upon anyone who begins to undertake to perform services for another's benefit.³⁴ However, it is not necessary for compensation to be intended, from any source, in order for there to be a duty imposed upon the doctor.³⁵

When a physician's purpose is care and treatment of a patient, the physician intends to establish a doctor-patient relationship and a duty of due care owed to the patient will always be found.³⁶ But, when a physician examines a patient for the sole purpose of gaining information for a third party, it is unclear whether a duty of care is owed to the patient.³⁷ The traditional view is that unless the examination has a therapeutic purpose,

27. Joseph H. King Jr., *The Duty and Standard of Care for Team Physicians*, 18 HOUS. L. REV. 657, 658 (1981).

28. *Id.*

29. RESTATEMENT (SECOND) OF TORTS § 314 (1965) (A private physician has no duty to enter into a relationship that would create a duty of care.).

30. King, *supra* note 27, at 661.

31. *Id.* at 663.

32. *Id.*

33. *See generally*, RESTATEMENT (SECOND) OF CONTRACTS §§ 133, 135, 139 (1973) (standing for the principle that contracts create a duty, but liability for the breach of that duty resulting in a personal injury will usually fall under the scope of tort law).

34. *See generally*, RESTATEMENT, *supra* note 29, § 323. *See also* W. PROSSER, THE LAW OF TORTS 347-48 (4th ed. 1971) (Prosser would not require that the plaintiff have been made worse by the doctor's action. A failure to act with reasonable care by the doctor is enough for liability according to Prosser so long as the harm could have been avoided.).

35. King, *supra* note 27, at 665.

36. Russell, *supra* note 23, at 302.

37. King, *supra* note 27, at 667-69.

a doctor owes no duty of care to a patient.³⁸ Courts have held, however, that the physician owes a duty to report dangerous conditions found during an examination to the examinee, even if no duty of care had been owed to him.³⁹ In *Betesh v. United States*,⁴⁰ the District Court for the District of Columbia ruled that even when a doctor conducts an exam primarily for the benefit of a third party, a duty is still owed to the patient.⁴¹ In *Betesh*, an Army doctor failed an applicant on his preinduction physical because of X-ray abnormalities, which later proved to be Hodgkins disease.⁴² The court ruled that the doctor had not only a duty to disclose any conditions actually discovered, but also a duty to conduct an examination with reasonable care in order to discover dangerous conditions.⁴³

This broad interpretation of a duty can be quite difficult to satisfy in a pre-employment examination for a professional athlete because athletes often lie about their medical conditions.⁴⁴ They know that failing a physical could cost them their chance in professional sports.⁴⁵ In order to limit physician liability due to an athlete's dishonesty, a physician can limit the scope of his duty of care by expressly communicating to the examinee that the extent of the particular relationship is to examine the patient for certain problems, but not to discover problems that a personal physician should discover.⁴⁶ The duty to alert patients of dangerous conditions actually found during the exam would still exist.⁴⁷

The duty and standard of care elements are the primary elements of

38. Russell, *supra* note 23, at 303.

39. See, e.g., *Bealding v. Sirotta*, 197 A.2d 857 (N.J. 1964); *Ranier v. Frieman*, 682 A.2d 1220 (N.J. Super. Ct. App. Div. 1996); *Greenberg v. Perkins*, 845 P.2d 530 (Colo. 1993).

40. 400 F. Supp. 238 (D.D.C. 1974).

41. *Id.* at 245-47.

42. *Id.* at 243.

43. *Id.* at 248-49.

44. ROB HUIZENGA, YOU'RE OKAY, IT'S JUST A BRUISE 76-77 (1994); Dr. Huizenga explained that potential NFL draftees would, without exception, lie about past injuries causing him to have to engage in "detective medicine." *Id.* Studies also have shown that athletes, as a group, "significantly underestimate the disruptive effects of injuries." GAL-LUP, *supra* note 15, at 92 (citing J. Crossman et al., *Perceptions of Athletic Injuries by Athletes, Coaches, and Medical Professionals*, 71 PERCEPTUAL AND MOTOR SKILLS 848-50 (Oct. 1990)).

45. HUIZENGA, *supra* note 44, at 76-77. For example, professional basketball player contracts have exceeded \$100 million. Selena Roberts, *N.B.A. Giving Birth to 9-Figure Contract*, N.Y. TIMES, July 15, 1996, at C1.

46. King, *supra* note 27, at 671; see e.g., *Nash v. Royster*, 127 S.E. 356, 359 (N.C. 1925) (explaining that a doctor may limit the scope of his relationship with a patient at the beginning of that relationship).

47. King, *supra* note 27, at 671.

medical malpractice that are at issue in cases involving professional sports team doctors.⁴⁸ When the duty element has been met, the standard of care element next must be addressed. The standard of care for most physicians is that of a reasonably competent practitioner in the class to which he belongs when acting under similar circumstances.⁴⁹ If a physician represents that he is a specialist, he will be held to the higher standards of that specialty.⁵⁰

Because team doctoring or even sports medicine was not considered a specialty in the past, a team physician was held only to "perform with the level of knowledge, skill, and care that is expected of a reasonably competent medical practitioner under similar circumstances."⁵¹ Although not specifically designated a specialty or subspecialty by the AMA,⁵² sports medicine now has been designated a specialty by the courts for the purpose of establishing a minimal standard of care.⁵³ In *Fleischman v. Hanover Ins. Co.*,⁵⁴ the Louisiana Court of Appeals upheld the decision of the trial court by ruling that a board certified orthopedic surgeon, who had an interest in sports medicine, was acceptable as an expert. Although there is still no actual standard of care for team physicians, they certainly could be held responsible for what other team physicians customarily⁵⁵ know or should know based upon the precedent set in *Fleischman*.

Given that the duty of due care is established, and the appropriate

48. Russell, *supra* note 23, at 301 (citing King, *supra* note 27, at 659-61). King explains that there are many other issues such as causation, damages, and Good Samaritan laws that could be important in determining liability. King, *supra* note 27, at 659-61.

49. Blair v. Eblen, 461 S.W. 2d 370, 373 (Ky. Ct. App. 1970).

50. Russell, *supra* note 23, at 305.

51. King, *supra* note 27, at 692.

52. GALLUP, *supra* note 15, at 9 (citing to the AMERICAN BOARD OF MEDICAL SPECIALTIES 6-7). The American Board of Family Practice, the American Board of Internal Medicine, and the American Board of Emergency Medicine all have created examinations to certify physicians of their respective specialties in sports medicine. To qualify to take the exam, physicians both must be certified by the appropriate specialty board and have completed either a one year sports medicine fellowship associated with an accredited residency in the applicable specialty or five years of practice of which at least 20% was devoted to sport medicine. GALLUP, *supra* note 15, at 3.

Once certified, the sports medicine certification remains intact when a team doctor travels out of state with his team except that he may not admit patients to hospitals. *Id.* at 4.

In addition, team physicians may belong to one or more specialty organizations such as the American College of Sports Medicine or the American Medical Society for Sports Medicine. If he belongs to a specialty organization, a court could presume that the team physician should know and follow the rules of that organization. *Id.* at 13.

53. Fleischman v. Hanover Ins. Co., 470 So. 2d 216, 217 (La. Ct. App. 1985).

54. *Id.*

55. King, *supra* note 27, at 688-91.

standard of care has been breached, the question that is often raised is why the physician is held liable and his employer is not. In *Western Union Telegraph Co. v. Mason*,⁵⁶ the Kentucky Court of Appeals ruled that when an employer voluntarily provides medical services for his employees, the employer is bound to exercise reasonable diligence only in the selection of competent physicians.⁵⁷ The employer was not responsible for the subsequent negligence of the physician.⁵⁸ Conversely, in *Knox v. Ingalls Shipbuilding Corp.*,⁵⁹ the United States Court of Appeals for the Fifth Circuit held that because the medical staff had been employed to further the goals of management, the doctrine of respondeat superior applied, thereby making the employer responsible for the subsequent negligence of his medical staff.⁶⁰ Notwithstanding the Fifth Circuit's holding in *Knox*, if a team doctor maintains autonomy in the medical treatment decision-making, he will usually be considered an independent contractor,⁶¹ and independent contractors are responsible for their own negligence. For example, in *Cramer v. Hoffman*,⁶² the United States Court of Appeals for the Second Circuit held that because a university retained no control over its team doctor's decisions, the doctor was an independent contractor.⁶³ Similarly, the State of New York was found to be relieved from liability when doctors employed by the state were negligent in the pre-fight examination of professional boxers, because the court ruled that those doctors were also independent contractors.⁶⁴

An exception to the general rule that a team physician is an independent contractor arises when a team physician performs a function over which the management of a team has actual control.⁶⁵ In *Chuy v. Philadelphia Eagles Football Club*,⁶⁶ the team physician falsely pronounced to the press that Chuy, a player on the team, had a fatal disease. Because the management of the team had a contractual right to control the team

56. *Western Union Tel. Co. v. Mason*, 22 S.W. 2d 602 (Ky. Ct. App. 1929).

57. Morley Ben Pitt, *Malpractice on the Sidelines: Developing a Standard of Care for Team Sports Physicians*, 2 COMM. & ENT. L. J. 579, 583 (1981).

58. *Id.*

59. *Knox v. Ingalls Shipbuilding Corp.*, 158 F.2d 973 (5th Cir. 1947).

60. *Id.* at 975. Under the doctrine of respondeat superior, an employer is liable for the torts of his employee even if the employer is without fault. Pitt, *supra* note 57, at 583 n.21.

61. J. WEISTART & C. LOWELL, *THE LAW OF SPORTS* 992 (1979).

62. *Cramer v. Hoffman*, 390 F.2d 19 (2nd Cir. 1968).

63. *Id.* at 22-23.

64. *Rosenzweig v. New York*, 158 N.E.2d 229, 232-33 (N.Y. 1959).

65. *Chuy v. Philadelphia Eagles Football Club*, 431 F. Supp 254, 265 (E.D. Pa. 1977), *aff'd*, 595 F.2d 1265 (3d Cir. 1979).

66. *Id.* at 257-58.

physician's statements released to the press, in contrast to his medical decisions which were beyond the team's control, the court ruled that the team was liable for the team physician's libelous speech.⁶⁷ Therefore, teams should be wary of their doctors assuming roles that go beyond the scope of normal medical duties because, under *Chuy*, the team could be responsible for non-medical activities of the team physician.

Workers' compensation statutes also are relevant in the context of team physician liability. Most of the injuries that occur inevitably in professional sports are covered by state workers' compensation statutes.⁶⁸ The fact that team doctors are not considered employees or ownership, but rather independent contractors, makes the doctors uniquely susceptible to liability.⁶⁹ If doctors were "co-employees" of teams along with the players, injuries resulting from the misfeasance or nonfeasance of team physicians would be covered under workers' compensation provisions covering negligent harm caused by co-workers in the course of employment.⁷⁰

III. PRESSURES ON TEAM PHYSICIANS CREATE CONFLICTS OF INTEREST

The conflicts of interest that team doctors must face can be overwhelming. Players,⁷¹ management,⁷² and the team doctor's own interests⁷³ exert pressure to help the team win. In the past, when team doctors have breached their duty to patient/athletes these pressures consistently have been the cause.⁷⁴

67. *Id.* at 264-65.

68. See WEISTART, *supra* note 61, at 1007-09.

69. Russell, *supra* note 23, at 310.

70. *Id.*

71. *E.g.*, King, *supra* note 27, at 692-93; (King explains that "an athlete may prefer to risk health for the sake of participation and success in a game."). *Id.* at 692.

72. *E.g.*, Russell, *supra* note 23, at 317 (explaining that management can put pressure on the team doctor in several ways which indirectly add up to a threat to his job).

73. See *infra* notes 119-141 and accompanying text; For example, Dr. Huizenga, though quite critical of Raiders' management throughout his book, constantly used the term "we" to refer to himself and the Raiders. He said, for example "we beamed going back through the tunnel" after making it to the Super Bowl. HUIZENGA, *supra* note 44, at 62; "I was proud to be a black-shirted Raider outlaw." *Id.* at 71. This certainly shows that Huizenga felt that he was part of the team and that he felt a sense of accomplishment in the team's making it to the Super Bowl. He could not have "beamed" or felt pride in winning if he had not felt the desire or pressure to win.

74. See *infra* notes 142-185 and accompanying text.

A. Pressures on Team Doctors from Players/Patients Themselves

It might be assumed that management puts all of the pressure on the team doctors to compromise medical ethics. Realistically, perhaps, the greatest pressure, in fact, comes from the players.⁷⁵ Players put pressure on team doctors to allow them to play with dangerous injuries because players, themselves, experience pressure from several sources to take risks with their health. First, "machismo" cannot be underestimated as a pressure effecting athletes.⁷⁶ Defined as an exaggerated masculinity,⁷⁷ machismo is a prevalent feature in professional team sports.⁷⁸ Tim Green, a former player in the National Football League ("NFL"), explained that NFL players experience strong pressure to show toughness.

Taking the needle⁷⁹ is something NFL players are proud to have done. It is a badge of honor, not unlike the military's Purple Heart. It means you were in the middle of the action and took a hit. Taking the needle in the NFL also lets everyone know that you'd do anything to play the game. It demonstrates the complete disregard for one's well-being that is admired in the NFL It is a certain sign of toughness and lets everyone know that that player can be counted on to "do whatever it takes."⁸⁰

Second, players face pressure from management to play with injuries.⁸¹ Coaches often encourage the macho image and may view the physicians with suspicion.⁸² Coaches are under great pressure to win. Accordingly, this translates into coaches putting pressure on their players to play when injured.⁸³ Some players avoid treatment altogether for fear that a coach would cut or replace them if the coach knew that they were

75. See generally, Pitt, *supra* note 57, at 581.

76. Pitt, *supra* note 57, at 588.

77. MERRIAM WEBSTER'S COLLEGIATE DICTIONARY 697 (10th ed. 1993).

78. Pitt, *supra* note 57, at 588.

79. The "needle" is a pain numbing shot of Xylocaine that often allows an athlete to play with an injury. GREEN, *supra* note 1, at 125. For an explanation of Xylocaine see PHYSICIANS DESK REFERENCE ("PDR") 562-65 (1997).

80. GREEN, *supra* note 1, at 125; Green gives an example of such machismo. He explained that his teammate's, Bret Clark's, taking shot after shot of Xylocane for an injured knee in order to play, was admirable. *Id.* at 126-28; "He took the needle every week. He was that tough. Everyone marveled at the pain and obvious physical damage this man endured in the name of winning. He was a team player, an example to us all." *Id.* at 126-28; Green was unsure if Clark was despondent or proud of his choice that left him damaged for life. *Id.* at 129.

81. E.g., Pitt, *supra* note 57, at 588.

82. Pitt, *supra* note 57, at 586-88.

83. John Underwood, *Punishment is a Crime*, SPORTS ILLUSTRATED, Aug. 28, 1978 at 36.

injured.⁸⁴ Dr. Rob Huizenga, a former team physician for the Los Angeles Raiders, and past president of the NFL Physicians Society, noted that "if you didn't play hurt, you risked going on [Raider Owner] Al Davis's [expletive] list."⁸⁵ He went on to say that such a reputation could end a player's chances of playing for that specific team and could ruin his chances of being traded or picked up by another team.⁸⁶ A former National Basketball Association ("NBA") player stated that "If [management] think[s] that you're not willing to play with a certain amount of pain, they can no longer use your services. . . . They'll find someone else willing to take the [pain numbing] shots and play hurt."⁸⁷

Peer pressure also can play a part in an athlete's desire to return from injury prematurely.⁸⁸ A former NFL trainer said, "[t]here's tremendous peer pressure to play with pain in this league . . . [those who] played in a great deal of pain . . . were respected and admired for doing it."⁸⁹ On the other hand, a player who is reluctant to play with an injury can be ridiculed by teammates.⁹⁰

The strongest pressure on athletes is most likely the threat of replacement. A former NFL team physician stated:

There was no job security; one bad game and they could be gone. There was always somebody on your shoulder. The vets had to hold off the rookies, and the young guys had to fight for playing time to prove their worth. When you did play, you were almost always going to end up playing hurt.⁹¹

Of course, the desire to play is motivated by economic considerations as well as a love for the game.

Other factors also pressure players to want to play. The media is one source of such pressure. For example, NFL commentator and former

84. Gerald Eskenazi, *Michaels Angered by Todd and Jet Doctor*, N.Y. TIMES, Nov. 11, 1977 at A25; (Walt Michaels, former coach of the New York Jets, used to peek into the trainer's room to see who was receiving treatment. Some players avoided the trainer's room for fear of being seen by Michaels.). *Id.*

85. HUIZENGA, *supra* note 44, at 120.

86. *Id.*

87. Jeffrey Mayer, *Playing with Pain*, L.A. TIMES, Aug. 29, 1978, at. *See generally*, *supra* note 81.

88. *E.g.*, Pitt, *supra* note 57, at 589.

89. Mayer, *supra* note 88, at 1; *supra* note 81.

90. Pitt, *supra* note 57, at 589; (For example, Fred Patek, a former Kansas City Royals shortstop, was told to stop feeling sorry for himself and to start playing by Royals teammates who were concerned about their chances of winning their divisional race but were not aware of the extent of his injuries.). *Id.*

91. HUIZENGA, *supra* note 44, at 120.

player, John Riggins, called Redskins wide receiver, Michael Westbrook, a "punk" on his local television broadcast because Westbrook missed several games due to injuries.⁹² Westbrook later returned to play too quickly from a knee ligament tear and was re-injured.⁹³ Additionally, some doctors even have asserted that players suffer from "Funktionlust," the love of doing a thing, which causes them to want to play even when it could be potentially harmful.⁹⁴

Obviously, some or all of these self-induced pressures result in a player's strong desire to play whether injured or not.⁹⁵ Some players may even lie to a doctor in order to get a chance to play.⁹⁶ The result is that:

Players beg doctors for needles [that numb] and drugs that reduce the swelling and pain . . . They'll do almost anything humanly possible to get back on the field. Only the elite players can afford to be immune from this diseased way of thinking and even most of them would do the same thing.⁹⁷

92. Dave Sell, *A Work in Progress: Martial Arts Accent Westbrook's Efforts*, WASH. POST, Oct. 23, 1996, at C1. Contributing to Riggins' assessment of Westbrook is the fact that Westbrook is flashy, drives a Lamborghini sports car and did not produce on the football field due to a string of injuries. Dave Sell, *Westbrook Out 3-6 Weeks with Knee Injury; Redskins' Receiver Won't Need Surgery for Ligament Tear*, WASH. POST, Sept. 19, 1996, at D1.

93. Richard Justice, *Monk-Like Westbrook is Now Imitating Art*, WASH. POST, Feb. 20, 1997, at E1 (explaining that Westbrook played with a partial ligament tear because his toughness had been questioned and tore the ligament completely, but still finished the game). Westbrook's status was listed as "day to day" in local newspapers despite the fact that doctors told the Redskins that Westbrook would have to miss four weeks of playing time. *Id.* This also demonstrates one way a team can use the media to motivate a player to play when injured.

94. King, *supra* note 27 at 693 (explaining the theory of Conrad Lopez which was further examined in Crile, *The Surgeon's Dilemma*, HARPER'S, May 1975, at 38).

95. GREEN, *supra* note 9, at 215; Green, a former NFL football player, believes that doctors do not coerce injured football players on to the field of play. He asserts that football players:

have been conveniently conditioned their entire lives to play with pain and put their bodies at risk. Players beg for needles that numb and drugs that reduce swelling or pain. Go ahead and treat them like a race horse or a fighting pit bull. They'll do almost anything possible to get out onto the field.

Id.

96. HUIZENGA, *supra* note 3, at 76-77 (explaining that potential draftees are never honest about their medical histories which result in team doctors engaging in "detective medicine").

97. GREEN, *supra* note 9, at 215-216; Studies have demonstrated that athletes significantly underestimate the extent of their injuries. GALLUP, *supra* note 15, at 92 (citing J. Crossman, J. Jamieson, & K. Hume, *Perceptions of Athletic Injuries by Athletes, Coaches, and Medical Professionals*, 71 PERCEPTUAL MOTOR SKILLS, 848-50 (Oct., 1990)). The fact that players may underestimate their injuries along with their desire to take risks can be a

B. Pressures on Team Doctors from Management

Management, to whom the team doctor owes a contractual obligation, can exert real pressure upon team doctors to compromise medical ethical standards.⁹⁸ Management can exert this pressure indirectly or directly through pressuring the athletes who, in turn, will pressure the team doctors,⁹⁹ through subtle questioning of a physician's competence,¹⁰⁰ through immoral guidelines set for the physician,¹⁰¹ or through scrutiny in interviews given to the media.¹⁰² Pressure by management contains the implicit threat that the physician will be replaced if he does not support management's policies.¹⁰³ For example, doctors might be told to withhold important medical information from the players. One team doctor explained the policy of an NFL football team to a new team doctor by saying that information must be kept from the players especially when it involves the length of time necessary for recovery:

Just be careful not to tell the players anything . . . You've got to treat them differently from your office patients. You tell them two weeks and their mind locks into that. And then what if they're ready in a week? They'll be nervous that they're not fully healed. They won't be mentally ready to play. Never put a date in their head.¹⁰⁴

Other team instructions or policies may force doctors to compromise their medical standards of treatment as well. Management may encourage a doctor to perform a less serious procedure than what is really necessary with a faster recovery period to minimize an athlete's time out

dangerous combination. For example, an athlete may only have a mild headache after a concussion. He may believe that he is capable of playing. However, he would be at great risk of second impact syndrome which causes severe brain injury or death. GALLUP, *supra* note 15, at 92, 114. One team doctor warns, "I'm not sure if [athletes are] willing to not play when they have a concussion and its the Super Bowl." Pollack, *supra* note 6, at 13.

98. See Russell, *supra* note 23, at 317; One NFL front office executive said that doctors feel pressure to get a player back from injury before he is ready 50% of the time. He said that when coaches perceive that the doctor is being too cautious, a coach might approach a doctor and say, "Let's go. Let's get them to play." Pollack, *supra* note 6, at 11.

99. See *supra* notes 82-88 and accompanying text.

100. Russell, *supra* note 23, at 317.

101. See HUIZENGA, *supra* note 44, at 58 (withholding information from players concerning their own health); *Id.* at 124 (attempting to never use stretchers); *Id.* at 142 (faking injuries to get onto the injured reserve list).

102. Eskanazi, *supra* note 84, at A25.

103. Russell, *supra* note 23, at 317; A former player stated that when management applies pressure upon the team physician, the doctor usually "folds." "The ones that don't fold end up being fired." Pollack, *supra* note 6, at 12.

104. HUIZENGA, *supra* note 44, at 58.

of action,¹⁰⁵ or management may encourage a team physician not to investigate an injury fully.¹⁰⁶ Management may believe that certain situations, such as witnessing a severely injured teammate on the field of play, can disturb the morale of the team.¹⁰⁷ Such a policy may cause the team doctor to be more reckless, for example, when examining neck injuries of injured players while they are still on the field.¹⁰⁸ Another policy of management may be to have the team physician overlook health problems that are unrelated to performance on the athletic field.¹⁰⁹ In one situation where a doctor alerted an athlete of a possibly cancerous growth, he was admonished by the management. Management said that once the team is "officially" aware of a medical condition, the team must attend to it.¹¹⁰

Ironically, it is sometimes to management's advantage to have its doctor overestimate the extent of an injury or even to be part of a lie regarding an injury to a player.¹¹¹ For example, in the NFL, a player can be put on an injured reserve list whereby he cannot play in any games, but can practice with the team¹¹² allowing teams to continue to keep many young "injured" players with the hope of grooming them for the future.¹¹³

105. See Pollack, *supra* note 6, at 11. Drew Rosenhaus, an agent, asserted that he represented players who were supposed to have reconstructive surgery, but were given lesser procedures so as to minimize a player's time out of action. *Id.*

106. *Id.* Agent Gary Wichert stated that a Magnetic Resonance Imaging Photograph ("MRI") of his client's injured ankle was not taken because the head coach ordered the doctor not to take the MRI. *Id.*

107. See HUIZENGA, *supra* note 44, at 124. One team doctor explained that the owner, "[did not] like stretchers. The team gets demoralized and plays less aggressively when they see a teammate getting carted off the field on a stretcher." *Id.*

108. HUIZENGA, *supra* note 44, at 123-24; Dr. Huizenga explained that he witnessed Dr. Rosenfeld move the neck of Kenny King, a Los Angeles Raider football player, when neither doctor had ruled out the possibility of a neck fracture. According to Dr. Huizenga, moving a fractured neck can lead to permanent paralysis. *Id.* According to the guidelines of the American College of Sports Medicine, a patient with a possible neck injury should have his neck immobilized until cervical spine X-rays are taken. ACSM, *supra* note 16, at 149-51.

109. See Ron Pollack, *Ethics Issue is not Limited to Football*, PRO FOOTBALL WKLY, Nov. 10, 1996, at 11.

110. *Id.*

111. HUIZENGA, *supra* note 44, at 141 (describing how the team openly conspired to force a player to fake an injury). Team physicians may also be forced to lie to the public by underestimating a player's injury. An agent asserted that, because of orders by the head coach, a team physician told the press that a player would miss only two weeks of action when, in actuality, the player should have missed the season. Two neutral doctors, who examined the athlete, concurred with the agent. Pollack, *supra* note 6, at 11.

112. HUIZENGA, *supra* note 44, at 141.

113. *Id.* at 141-42.

Team physicians are often a party to the deception. Some team physicians have even coached players on how to feign injury during physical exams by independent doctors.¹¹⁴

Since the management of professional sports teams is constantly in the public eye, management is in the position to influence its team doctors through the media.¹¹⁵ For example, former New York Jets head coach, Walt Michaels, expressed his anger to reporters that his team's doctor admitted Richard Todd, the team's starting quarterback, to a local hospital without first obtaining the permission of the coaching staff.¹¹⁶ Michaels even attempted to fine the doctor for doing so.¹¹⁷ Michaels learned of Todd's hospitalization through the media and chose to get back at the doctor by berating him in the media.¹¹⁸ This type of situation rarely occurs, as evidenced by the datedness of the Michaels example, because management usually can just as easily fire the team physician as disparage him in the media, but the possibility always exists.

C. Self-Pressures of Team Doctors

Less apparent and frequently underestimated are the self-imposed pressures that a doctor often faces. These pressures are a result of two factors. First, team doctors routinely believe or want to believe that they are part of the team and, therefore, may experience the pressure to sacrifice a player's health for the sake of team success.¹¹⁹ Second, a team doctor may put undo pressure on himself to please management so he can keep his position due to the many benefits he receives from his status as a professional sports team doctor.¹²⁰

Most sports physicians chose this area of work because they are fans and enjoy competitive sports.¹²¹ Teams often allow their doctors to participate in team camaraderie, which contributes to the doctors' impressions that they are part of the teams.¹²² Unlike most doctor-patient

114. *Id.* at 142.

115. Eskanazi, *supra* note 84, at A25.

116. *Id.*

117. *Id.*

118. *Id.*

119. *See infra* notes 121-23 and accompanying text.

120. *See infra* notes 124-36 and accompanying text.

121. *See generally*, Thomas H. Murry, *Divided Loyalties in Sports Medicine*, THE PHYSICIAN AND SPORTS MEDICINE, Aug. 1984, at 136 (stating that team physicians often want the team to win as badly as management does).

122. *E.g.*, HUIZENGA, *supra* note 44, at 71 (stating, "I was proud to be a black-shirted Raider outlaw.").

relationships, it is not uncommon for the team doctor to go to movies with players,¹²³ join players in card games,¹²⁴ or "party" with the players at either official¹²⁵ or unofficial¹²⁶ team functions. Team physicians have received game balls in front of the entire team for exemplary performances during games.¹²⁷ The team mentality can cause a doctor to experience the same emotional highs and lows that come from winning and losing games that players and coaches experience.

One doctor explained after a playoff game loss:

We sat in solemn silence, heads hung, with that helpless, hopeless knot in the pit of the stomach. I could remember feeling pretty despondent after tough wrestling losses in college, but I had no idea I'd feel this bad now. I was only the doctor, but I had an incredible urge to punch the wall.¹²⁸

After winning the Super Bowl, the same doctor said "We sprayed and gulped champagne with glee," and that he "was proud to be a black-shirted Raider outlaw."¹²⁹

A doctor also may put pressure on himself to help the team win, first and foremost, because the position of team doctor has many perks.¹³⁰ The pay that team doctors receive is insignificant compared to these extra benefits.¹³¹ One team doctor estimated that his salary during the 1980's amounted to about eight dollars per hour.¹³² Most recently, some doctors actually have paid teams up to one million dollars for the rights to take care of their players.¹³³ Jay Pearce, a member of a group of doctors for the Orlando Magic, explained that it makes economic sense to pay to be the team's doctors. He said, "[a] lot of [orthopedic surgeons] would be willing to be sponsors We want the world to know that we do take care of the team."¹³⁴ Being connected to the local sports team can give a

123. *E.g., id.* at 36 (The team physician went with players on the team "movie bus" to see tough-guy movies).

124. *Id.* at 44-45.

125. *Id.* at 104-05 (Team doctor was invited to the rookie sponsored training camp team party where he was considered a "rookie.").

126. *Id.* at 96 (The team physician spoke of the times he spent with the players socially and that the players never let him pay for a bar bill.).

127. HUIZENGA, *supra* note 44 at 149, 204-05.

128. *Id.* at 133.

129. *Id.* at 71.

130. See Joseph Nocera, *Bitter Medicine*, SPORTS ILLUSTRATED, Nov. 6, 1995 at 82.

131. *Id.*

132. HUIZENGA, *supra* note 44, at 59.

133. Nocera, *supra* note 130, at 84.

134. Lester Munson, *Bitter Medicine*, SPORTS ILLUSTRATED, Nov. 6, 1995, at 84.

doctor a great amount of visibility.¹³⁵ When a child tears a knee ligament playing high school football or field hockey or simply falls off his bicycle and breaks his leg, concerned parents will want the best doctor, and who would be better than the team doctor of the local professional team?¹³⁶

For a team internist, who may not benefit as much as an orthopedic surgeon could from the exposure,¹³⁷ there are also many potential benefits. Many athletes continue to see a team internist as their private doctor after they retire,¹³⁸ which gives the doctor a lucrative patient base because ex-athletes invariably have health problems. Another potential benefit is a share of the team's playoff bonus money.¹³⁹ For a team internist, a playoff bonus share could triple his salary.¹⁴⁰ Certainly, this could raise questions about bonus money tipping the balance of a doctor's interest in favor of winning in the short term over the long term health of a player. Of course, who would not want a seat right on the sideline, a free trip to the Super Bowl or the World Series, or a championship ring that may be given to the winning team's doctor?¹⁴¹ All of these extra benefits add to the weight of the pressures to win that team doctors experience, and ultimately may compromise patient care.

IV. CONFLICTS OF INTEREST CREATE EXPOSURE TO TORT LIABILITY

The strong pressures creating conflicts of interest for the team physicians may cause a team physician to make mistakes in medical judgement. Recently, Ron Morris of the NFL's Chicago Bears was awarded 5.3 million dollars by a jury because his team's doctor negligently performed a

135. Nocera, *supra* note 130, at 82 (noting that one of the benefits an orthopedic surgeon for the Boston Red Sox received was "a kind of visibility that orthopedic surgeons can only dream about").

136. *Id.* See also HUIZENGA, *supra* note 44, at 74-75.

137. HUIZENGA, *supra* note 44, at 74-75 (explaining that people are more likely to go to a team orthopedist than a team internist because when someone has an orthopedic injury, the NFL orthopedist appears to be the best doctor, but if "your mother had a stroke or developed diabetes, you wouldn't instinctively run to the nearest NFL city and look up the team internist").

138. *Id.* at 153 (stating that many veteran players would continue to see a team physician after retiring from athletics). However, Kevin Glover of the NFL's Detroit Lions said, "I don't think that the doctors really have a whole lot of loyalty to the players. It's not like the players are going to be in contact with these doctors once [players] retire." Pollack, *supra* note 6, at 10.

139. HUIZENGA, *supra* note 44, at 70. Dr. Huizenga explained that though playoff bonus money was fairly insignificant to the players, a playoff share could match, double, or even triple the salaries of many of the staff including the team internist. *Id.*

140. *Id.*

141. *Id.* at 59.

routine knee procedure.¹⁴² The doctor was so desperate to retain his position as team doctor that he erased the videotape of the operation.¹⁴³ Another example of management pressure causing a team doctor to make a medical mistake involved Glenn Seabrooke, a prospect of the National Hockey League's ("NHL") Philadelphia Flyers,¹⁴⁴ who had injured his shoulder during a game.¹⁴⁵ At trial, memos were introduced into evidence from the team medical staff to Flyer management wherein the medical staff promised that they would be "beating on Seabrooke all summer."¹⁴⁶ They pushed Seabrooke so hard that he developed dead arm syndrome which left his shoulder and arm useless and in constant pain for life.¹⁴⁷ A jury awarded Seabrooke 5.5 million dollars.¹⁴⁸

An extreme example of the intense pressure to win leading to a medical mistake in judgment involved Houston Ridge, a lineman for the NFL's San Diego Chargers. After suffering a hip injury, Ridge was given speed and phenobarbital and sent back into a game.¹⁴⁹ Ridge aggravated the injury by fracturing his hip during the game, but later said that he was so high on amphetamines that he did not realize he had broken his hip.¹⁵⁰ The injury ended his career and he settled his case out of court.¹⁵¹

The aforementioned cases are extreme, and relatively rare, examples of medical malpractice. It takes much more action on the part of a physician to hurt a player through poorly performed treatment than it does to expose a player to a treatment without making him aware of the risks. Players constantly are being treated. It can be quite easy to send a player back into action without having first informed him of the risks of playing after a specific treatment. Therefore, when conflicts of interest that team physicians face cause them to make tortious mistakes, those mistakes usually take the form of either a failure to obtain informed consent from the patient or an intentional fraudulent concealment of information.¹⁵²

Informed consent is a legal doctrine that requires a physician to obtain

142. Nocera, *supra* note 130, at 80-81.

143. *Id.*

144. Munson, *supra* note 134, at 81.

145. *Id.*

146. *Id.*

147. *Id.*

148. Nocera, *supra* note 130, at 81.

149. Pitt, *supra* note 57, at 597. For a description of phenobarbital, see PDR, *supra* note 80, at 2234-35.

150. Pitt, *supra* note 57, at 597.

151. *Id.* See also Thomas H. Murry, *Divided Loyalties in Sports Medicine*, PHYSICIAN & SPORTS MEDICINE, Aug. 1984, at 136.

152. ACSM, *supra* note 16, at 121.

permission from his patient before using any diagnostic procedures or rendering any treatment.¹⁵³ The American College of Sports Medicine establishes no guidelines for determining what constitutes adequate or truly informed consent.¹⁵⁴ Generally, however, what the team physician is required to disclose before administering care is the diagnosis, the nature and purpose of the proposed treatment, the risks and consequences of that treatment, and the prognosis of alternative treatments including non-treatment.¹⁵⁵ A patient/athlete must understand to what he is consenting; without understanding, no consent exists.¹⁵⁶

One of the first cases involving informed consent in professional team sports concerned a member of the NFL Hall of Fame, former Chicago Bear linebacker, Dick Butkus.¹⁵⁷ Butkus, who had a chronic knee injury, was treated with cortisone on a weekly basis for four years.¹⁵⁸ He alleged that he was never told how serious his injuries were and that he would have been fined or suspended if he had refused to play.¹⁵⁹ His case was settled out of court.¹⁶⁰

Perhaps the best known case involved former NBA star, Bill Walton.¹⁶¹ Walton alleged that the team doctors of the Portland Trailblazers, where he played, never informed him of the lasting damage being done to his feet while they were numbed by painkillers.¹⁶² Walton asserted that his subsequent bone fracture would not have occurred if not for injections of Xylocaine, Marcaine, and Decadron.¹⁶³ This case clearly demonstrates the pressures on players because, early in his career, Walton had refused to take painkilling drugs.¹⁶⁴ The press, the fans, team officials, and even some of his teammates began to call him a "malingerer."¹⁶⁵ The pressure

153. GALLUP, *supra* note 15, at 40.

154. ACSM, *supra* note 16, at 122. The guidelines only say that possible rather than probable risks should be disclosed and legal advisors should be consulted. *Id.*

155. GALLUP, *supra* note 15, at 40.

156. *Id.* at 41. For example, information provided must be in layman's terms according to what the patient would want to know. *Canterbury v. Spence*, 464 F.2d 772, 780-82 (D.C. Cir. 1972).

157. Murry, *supra* note 151, at 136.

158. Russell, *supra* note 23, at 321.

159. Murry, *supra* note 151, at 136.

160. *Id.*

161. Russell, *supra* note 23, at 320.

162. Nocera, *supra* note 130, at 84.

163. Russell, *supra* note 23, at 320. See also John Papanek, *Off on a Wronged Foot*, SPORTS ILLUSTRATED, Aug. 21, 1978, at 20. For a description of Marcaine and its effects, see PDR, *supra* note 80, at 2446-49. For a description of Decadron, see *id.* at 1676-88.

164. Papanek, *supra* note 163, at 20.

165. *Id.*

to win finally caused Walton to begin taking shots in his foot.¹⁶⁶ His suit also was settled out of court.¹⁶⁷

The doctrine of informed consent is not limited to the area of numbing injections. Kenny Easley of the NFL's Seattle Seahawks sued his former team doctors for allowing large doses of over-the-counter medication to be available in an open bin without a doctor's supervision or warning.¹⁶⁸ He claimed that this medication aggravated a later diagnosed kidney problem.¹⁶⁹ He too settled out of court.¹⁷⁰ Other cases have included situations where players were deceptively given drugs,¹⁷¹ or not made aware of the risks of using drugs.¹⁷²

The first major case that changed and established the rules for team doctors was *Krueger v. San Francisco 49ers*.¹⁷³ Charles Krueger, the plaintiff and a former NFL player, alleged that the team physicians had gone beyond mere lack of informed consent to intentionally and fraudulently concealing¹⁷⁴ meaningful information when treating him.¹⁷⁵ Krueger had been given "Kepplemann treatments," injections of novocain and cortisone, in his knee on a regular basis without ever being told that such treatments could possibly rupture tendons, weaken joints and cartilage, and destroy capillaries and blood vessels.¹⁷⁶ The court held that a physician cannot avoid responsibility simply by claiming that information was not withheld,¹⁷⁷ and that this concealment amounted to fraud.¹⁷⁸ One team doctor described the true effect of the ruling:

If a doctor gave knee injections and the player understood the risks and benefits and agreed, that would be good medicine. If a

166. *Id.* at 21-22.

167. Nocera, *supra* note 130, at 84.

168. HUIZENGA, *supra* note 44, at 238.

169. *Id.*

170. *Id.*

171. See Pitt, *supra* note 57, at 595. Ken Gray of the St. Louis football Cardinals alleged that he was deceptively given drugs which made him perform more violently. *Id.*

172. Pitt, *supra* note 57 at 594. In *Mendenhall v. Oakland Raiders*, the player alleged that he was given amphetamines without being told the risks involved. No. 441-241 (Cal. Super. Ct., Alameda County, Sept. 28, 1973).

173. 234 Cal. Rptr. 579 (1987).

174. The elements of an action for fraudulent concealment (fraud or deceit) are a misrepresentation or suppression of a material fact, knowledge of any falsity, intent to induce reliance, actual and justifiable reliance, and resulting damages. *Muraoka v. Budget Rent-a-Car*, 160 Cal. App. 3d 107, 119 (1984).

175. *Krueger*, 234 Cal. Rptr. at 582-83.

176. *Id.* at 581.

177. *Id.* at 583.

178. *Id.*

doctor gave knee injections, explained the risks and benefits, but mistakenly stuck the needle into the cartilage and damaged it, that would be malpractice. If a doctor, however, recommended knee injections and knowingly withheld possible future risks from the player, or went on giving injections when complications became apparent, that would be fraud. Your basic doctor's malpractice insurance does not cover fraud. So in this type of judgment, the doctor pays with his car, his house, his wife, his firstborn kid, whatever.¹⁷⁹

A recent unpublished case reinforces the doctrine of fraudulent concealment established in *Krueger*. More importantly though, a team doctor's financial interest in the team was argued to be a conflict of interest, which explained why the standard of care was breached.¹⁸⁰ In *Barrett v. Pappas*, the team doctor of Major League Baseball's ("MLB") Boston Red Sox, removed part of the ruptured anterior cruciate ligament of Red Sox second baseman, Marty Barrett. Dr. Pappas told Barrett and the press, however, that Barrett had suffered only some torn cartilage.¹⁸¹ Pappas owned five percent of the team¹⁸² and was privy to management's long term decision not to keep Barrett.¹⁸³ Barrett's attorney argued that because Pappas was part of management, there was a clear conflict of interest between Pappas' obvious financial stake in the team and the best interests of his patient.

As stated earlier, all team doctors have some financial interest in the teams for which they work.¹⁸⁴ Based upon the arguments presented in *Barrett*, proving a financial interest in the team's success may be strong evidence that a team doctor is predisposed to breaching his duty of care to his patients. A recent trend in professional sports is to have the team physicians sponsor teams or become partners in the organizations.¹⁸⁵ The decision in *Barrett* could expose these physicians to quite damaging and expensive liability.

179. HUIZENGA, *supra* note 44, at 195.

180. Nocera, *supra* note 130, at 87.

181. *Id.* at 74, 80.

182. *Id.* at 82.

183. *Id.* at 88.

184. See notes 129-40 *infra* and accompanying text.

185. *Hypocritic Oath*, SPORTS ILLUSTRATED, May 8, 1995, at 12; Lester Munson, *Fast Operators*, SPORTS ILLUSTRATED, Nov. 6, 1995, at 84. Under the informed consent doctrine, a physician must disclose his personal and financial interests when treating a patient. *Moore v. Regents of the Univ. of Cal.*, 51 Cal. 3d 120, 129, 793 P.2d 479, 483 (1990); *but cf.* Rodwin, *supra* note 2, at 214-16.

V. ANALYSIS OF POSSIBLE SOLUTIONS

When physicians have interests in anything other than their patients, conflicts become a real possibility. The more conflicts of interest, the more the potential exists for the doctor to harm the patient and to incur liability.¹⁸⁶ It seems that many interested parties already believe that team physicians will favor their employers over their patients. For example, when asked who they thought team physicians will favor in a conflict, 96.2% of NFL agents surveyed stated that the physicians will favor management.¹⁸⁷ Players themselves are convinced that doctors favor management. An NFL player who was pressed to return early from injuries explained:

It's tough being a team doctor. They're an extension of the coaching staff. Sometimes they don't want to be in the position they're in, but they don't have a choice. What I learned is a lot of control is out of their hands. They can't afford to be as caring as you'd like them to be because everybody has got to eat.¹⁸⁸

The perception that team physicians are controlled by management is correct according to Richard Berthelsen, the general counsel for the National Football League Players Association. He remarked that team doctors "almost invariably side against players in arbitration hearings claiming that players' injuries are not related to football."¹⁸⁹

What should be done? Dr. David Fischer, medical director for the NFL's Minnesota Vikings, suggests that no problem exists. He asserts that "there's no incentive for me to jeopardize a player's health. My position and my credibility and my reputation ultimately depend on being a good doctor."¹⁹⁰ However, as stated earlier, player health has been jeopardized in the past and, most likely, will continue to be jeopardized. Additionally, Dr. Fischer and other team physicians should realize that, potentially, unhappy management could fire them for performing their duties with the level of accepted caution required for normal patient care.

186. See HUIZENGA, *supra* note 44, at 209; For example, if because of his status, a team doctor learns that an opposing team's player will be suspended for a violation of the league drug policy before an upcoming game, the desire to tell his team's coach becomes tremendous. *Id.*

187. Pollack, *supra* note 6, at 10. When agents were asked how often team doctors feel pressure to rush a player back from injury before he is ready to play, 19.2% voted "all of the time"; 26.9% voted "three-quarters of the time"; 42.3% voted "half of the time"; 11.5% voted "one quarter of the time"; 0.0% voted "never". *Id.*

188. *Id.* at 12.

189. Nocera, *supra* note 131, at 84.

190. Pollack, *supra* note 6, at 10.

Moreover, the negative publicity that could result from being fired by a professional sports team could be almost as devastating to his reputation as a specialist as providing substandard care.

There are several possible solutions to reduce the conflicts affecting team doctors. One solution is for team doctors to get tough with their employers. Experts have suggested that doctors must convince management that the decisions of the team doctor are final,¹⁹¹ or make it clear to management that medical services are not associated with winning.¹⁹² These are naive proposals. The reality is that management can replace the team doctor at any time, and there will be several others ready to replace him. Team doctors are in no position to make demands. Some doctors pay millions of dollars¹⁹³ just for the right to serve as team doctors because of the extra benefits the position holds. Consequently, teams do not have much difficulty finding replacements for demanding doctors.

The only solutions to possibly compromised medical care that will work are those that reduce the many pressures to win that a team doctor experiences. When considering the pressures applied by the players, a team doctor must decide if he should attend to the players' medical needs or honor their choices.¹⁹⁴ If a doctor believes that a player is capable of making the decisions, he simply has to inform the player satisfactorily of all of the risks of any particular treatment and its alternatives. The real problem of informed consent arises not during practice or in the trainer's room, but during certain "heat of battle" situations. The difficult dilemmas of game time decision-making could be eliminated if the doctor were to inform the players of certain treatments that they possibly could receive during a game and ask them to which treatments they would consent and to which will they not consent before the situation arises. Certainly, a very short written questionnaire/waiver could be kept for each player so that the physician could have instant access to the wishes of a player regardless of what he says during a game. Athletes are more in touch with their bodies and are better able to make determinations about the risks of participation than a non-athlete or even a physician.¹⁹⁵

191. King, *supra* note 27, at 692 n.131 (noting the theory of Olsen).

192. *Id.* (noting the theory of Olgilvie).

193. Munson, *supra* note 144, at 84.

194. King, *supra* note 27, at 698.

195. Russell, *supra* note 23, at 318. However, studies have shown that athletes underestimate their injuries. GALLUP, *supra* note 15, at 92 (citing J. Crossman, J. Jamieson, & K. Hume, *Perceptions of Athletic Injuries by Athletes, Coaches, and Medical Professionals*, 71 PERCEPTUAL AND MOTOR SKILLS, 848-50 (Oct. 1990).

Therefore, if the athlete is informed, he should make his own decisions, but at a time of unquestionable lucidity. The doctor must address the player's needs instead of the player's wishes and should stop the athlete from participating only when there are significant risks of harm from participation.¹⁹⁶ These risks must be so great, such as paralysis or death, that the decision should be taken out of the patient/athlete's hands. Otherwise, the physician only should make the athlete's decision for him when the athlete is not lucid.¹⁹⁷

One way to decrease the pressure on team physicians to win is to prohibit the team doctor from acting as part of the team. He should not socialize with the players or the management. He should not receive a playoff share or a championship ring. He only should see the players on a professional level. He should not participate in team trickery such as faking injuries to get players on the injured reserve list or to stop the game clock.¹⁹⁸ Only then can the doctor make sound decisions regarding what is best for a player's health rather than what treatment will best enable the team to win.

Most importantly, however, the economic incentives for being a team doctor must be controlled. One solution would make a physician the league's employee.¹⁹⁹ Physicians would have some autonomy and would rotate cities every few years to minimize partisanship to one team.²⁰⁰ This may work to the extent that some partisanship will be eliminated. However, top doctors will not find this attractive because the constant moving will not allow them to maintain a practice outside of team doctoring. These rotating doctors, therefore, would become subjected to the whims of the league even more so than team doctors are now subject to the whims of management because, at least, team doctors today have private practices upon which they may fall back.

One agent, Drew Rosenhaus, suggests eliminating the "team" doctor completely so that management has no contact with or control over the team doctor whatsoever.²⁰¹ This could work because some sports do not need a team doctor. In basketball and baseball, for example, no team

196. King, *supra* note 27, at 699.

197. *Id.* One could assert that "heat of battle" thoughts are not lucid thoughts. *Id.* at 700. Yet, the definition of lucidity should remain at a low standard because one could even assert that to play violent contact sports requires a lack of lucid thought.

198. Russell, *supra* note 23, at 324.

199. *Id.* at 325.

200. *Id.*

201. Ron Pollack, *A Possible Solution to the Problem*, PRO FOOTBALL WKLY, Nov. 10, 1996, at 13.

doctor is necessary. Upon injury in these sports, management could provide the players with a list of several specialists from which they could choose. A group of rotating doctors could take turns sitting in at games in case of an emergency. No one publicly could claim to be the team doctor, and all doctors could serve a fixed term on the list. In football, however, there are so many severe injuries and players that there must be at least one doctor at every game and practice.²⁰² A diverse group of doctors could still treat an NFL team so long as the game day doctor was adequately informed of the special needs of certain players. These doctors should be paid, certified, and hired by the league or the players' union²⁰³ and supervised by an impartial board²⁰⁴ so that team camaraderie, loyalty, and economic pressures are kept to a minimum.

Furthermore, all professional sports leagues should certify their own team doctors. The particular athletes for each sport usually have similar problems to other athletes throughout their sport, but different problems than athletes involved in other sports. A general sports medicine interest is not sufficient to treat professional athletes. For example, knowing how to cool down an overheated 330 pound lineman will not translate into knowing how to treat a pitcher with a sore shoulder.

Players also should be encouraged to take a more active role in their medical care. More players need to request second opinions.²⁰⁵ Players have a right to these opinions under their collective bargaining agreements, and teams are required to pay for them.²⁰⁶ However, players are scared that the team will look down upon them and the medical staff will refuse future treatment if a second opinion is sought.²⁰⁷ Consequently,

202. DAVID L. HERBERT, *LEGAL ASPECTS OF SPORTS MEDICINE* 138-39 (1990) (recommending that physicians be present at all football games and practices).

203. Pollack, *supra* note 201, at 13. National Football League Players Association Executive Director Gene Upshaw stated, "The easiest way [to eliminate the conflict of interest problem] is for the players and the owners to pick the doctor together. Jointly come up with a panel or a team of doctors that you can use." *Id.*

204. *Id.* Dr. Huizenga suggests that an impartial group of doctors at a local academic center or a state board should supervise team doctors. *Id.*

205. Arthur Caplan, Director of the University of Pennsylvania's Center for Bioethics said, "I'd like to suggest an unbreakable rule that requires every professional [sports] league to issue a Miranda-style warning to every player informing him that he not only has the right but the obligation to get his own personal physician." *Hypocritic Oath, supra* note 185, at 12.

206. GREEN, *supra* note 1, at 216.

207. Pollack, *supra* note 6, at 13 (quoting Wichard regarding his client's fear to seek a second opinion); One former NFL player asserted that "NFL teams look at second medical opinions about the same way you might look at the bottom of your shoe after walking through a cow pasture." GREEN, *supra* note 1, at 216.

team doctors should encourage these second opinions for the health of the players and to limit their own potential liability.

No case yet has set the standard of care for professional team physicians. Therefore, doctors should be wary of their conflicts of interest. The more conflicts of interest that exist, the more likely that a jury will find that the doctor had a reason to breach the standard of care. The potential expansion of the *Barrett* decision to all doctors who have any economic interest in teams should give pause to anyone considering being a team doctor. One must weigh the potential for tremendous liability against the benefits that come from being associated with a team. Certainly, at a minimum, it will discourage well informed team doctors from engaging in any ownership activities.

VI. CONCLUSION

A team doctor is held to the standard of care of a specialist. Yet, because no AMA guidelines exist, this standard is not certain. Regardless of the specific standard of care, a variety of pressures act as incentives for team doctors to breach the standard. The players pressure team doctors to disregard the standard of care so that players can get back on the field quickly. The team doctor can be influenced by management, which is concerned about the success of the team, through the tacit threat that he can be replaced at any time if he coddles the players. Most importantly, the team doctor experiences self-imposed pressure. Most team doctors are fans who want their teams to win. They socialize with the players and management, and they are the envy of their friends as a result of this access. A large amount of their business can be a direct result of their exposure from and association with the team. Bad exposure resulting from being dismissed from the team could damage business. Additionally, what doctor wants to be the one to force the quarterback to miss the Super Bowl? Who wants to be the villain that ruined the hometown's chance at glory? Who would not want to be a part of that glory with a Super Bowl ring to prove it?

So many conflicts and potential conflicts of interest push the team doctor away from cautious medicine. If he is negligent, however, he alone will have to pay the damages, and if he conceals information, his malpractice insurance may not cover those damages. Yet, doctors are paying millions for the opportunity to be a team doctor. Some policies, if implemented, can help shield the team doctor from liability, but conflicts of interest are almost inherent in the job description of a professional

sports team physician. Team physicians and their attorneys must be aware of these conflicts of interest because the sweetness of a championship can be soured quickly and easily by expensive tort litigation.

Scott Polsky

